

From: Susan Israel [REDACTED]
Sent: Monday, November 25, 2013 1:47 PM
To: SIM, OHA
Subject: Public Comment on the SIM Draft

Thank you for this opportunity to make Public Comment on the SIM Draft. Susan Israel, MD

The exact number of people that will have authorized access to the patient medical record, besides the team of the Advance Medical Home, needs to be made fully transparent to the public. I would like to focus first on the crucial issue of privacy, then on some issues for providers.

Apparently, there are many categories of people that will participate in the medical surveillance of patients in order to direct the health care system. I wonder if the people who created the SIM plan, really see themselves as being treated by an Advanced Medical Home team, rather than by the private single provider whom they probably see now. The SIM draft makes references to concern for privacy, but there will be none. At best, there will be confidentiality which means non-inappropriate disclosure, and we all have to hope there will be no hackers into the multiple data bases. As per the draft:

(p. 43) "Team-based coordinated care: Multi-disciplinary teams offer integrated care from primary care providers, specialists and other health professionals..." "Initially on a pilot basis and eventually more widely, we anticipate more fully integrated care teams with specialists, behavioral health providers, physician extenders, dietitians, pharmacists, oral health providers and community health workers." So who won't see the medical record?

AMH: Core Elements:

1. "Assess whole person and family with appropriate tools to identify strengths and preferences; risk factors; medical, behavioral health, psychosocial, and oral health ..." So this means that your psychiatric records will be available to the whole team and including your dentist?
2. "Prioritized Interventions: Regularly profile health patterns and improvement opportunities for particular patient sub-populations (including those defined by health risk, condition, race, ethnicity, primary language, sexual orientation and other demographic data.)" So this means that now all will know about your sexual practices and that you will be tracked to be helped, if not pressured financially, to make changes to risky behaviors, which could include smoking or being overweight.
3. "Aggregate de-identified data with State and payers to facilitate analyses, reporting and intervention."

Please keep in mind that the HIPAA rules for the de-identification of data can be argued to be inadequate to protect privacy, especially since the rules were created prior to the explosion of electronic systems promoted by the ARRA (Stimulus Bill) of 2009. Before the data are aggregated for release publically to the State and payer, how many SIM oversight people and State agencies, such as that of the Dept. of Public Health, will process the identified medical records?

SIM needs information from the Health Insurance Exchange – HITE-CT that will process the whole electronic medical record. Now that SIM wants that data, will we be able to Opt-out of our records being in the exchange? The goal is to put all our information into the hands of a Clearing House (p. 80) as the "State will transition to a clearing house (HIE) model for clinical data exchange....The taskforce will coordinate efforts across programs as they integrate clinical and claims data and to produce a more complete picture of provider

performance.” The *Clearing House and the taskforce* will be composed of whom and in what form will they see our medical data?

The following is the list (p. 81) of what will be done with patient records “with respect for privacy in the informatics/HIT revolution that affords unprecedented capabilities in:

- record keeping and retrieval,
- answering clinical questions and identifying best practices,
- quality control and error reduction,
- data generation and analytics on outcomes and processes,
- simulation, distance learning and e-consultation,
- monitoring of patients in their homes, and
- communication by clinicians and other care givers among themselves, with patients and their families and with *researchers and educators*”

“High priority changes include:

- Collecting ... demographic data, including race, ethnicity...to monitor health quality and outcome and to inform service delivery
- Using ...to understand specific risks for one’s own panel, ... and individual patients
- Maintaining a disease registry
- Partnering with certified community bases entities and other social service and support entities to address clinical and support needs when necessary
- Aggregating de-identified data with State payers to facilitate analyses, reporting and intervention”

Again, please note that even the so called “de-identified data” can be *re-identified* by the cross referencing and merging with the many other data bases available.

It seems that the above tracking and oversight by SIM people will be done using *identified* medical records, as (P. 78) “... we will integrate public health and clinical data analytics so providers have more meaningful performance information and consumers possess a more comprehensive view of their care.” (This patient medical information would be added to that already seen by the Dept. of Public Health in the identified Tumor Registry and Hospital Discharge data, sent *without* patient consent.)

Will SIM people intercede with medical decisions at the “point-of-care” during “Evidence informed clinical decision making” and be authorized to see patient medical records in doing so (p. 6)?

(p. 57) “Certified entities can improve the DPP’s outcomes by using Health Information Technology (HIT) to connect closely to the AMHs and incorporate data even more evidence-based care into the DPP.” (p. 109) “Integrated primary care and population health: Connecticut is considering certifying Community-based Practice Support Entities (Certified Entities). This will standardize services offered by community organizations and make quality services more transparent and accessible to primary care practices. Because this is a new function, the state may need to expand the mandate of current state organizations (e.g., DPH) or establish a new entity.” So how many more people of these Certified Entities will see patient data without consent?

And then the oxymoron: (p. 109) “Address privacy concerns to expand APCD’s usefulness:

An All Payer Claims Database (APCD) is being developed at the state level. Cross-payer claims data could generate detailed, *actionable* analytics on *individual* consumers, which could then meet payer data collection requirements for the HIE. In an example, the State of Arkansas’ State Innovation Plan has proposed an APCD

that will profile provider patient panels, create patient registries, measure quality, and better position the state to meet any payer data collection requirements for their HIE. However, Connecticut's current policy governing APCD prohibits its use for these purposes due to privacy concerns. The state will consider changing this policy so that the APCD can provide *detailed analytics at the individual level.*" (p. 109) If the above plan is to incorporate the APCD data with the clinical record, then the data would have to be *identified* and thus create major privacy issues?

The APCD will be a centralized data base with our enrollment data, identifiers, diagnoses, names of providers, hospitalizations, tests, procedures and drugs prescribed, all with dates. So this means that intimate Ob-Gyn, urology and psychiatric data, as examples, will be made available to how many people without patient consent? The APCD law (HB 6706, PA 13-247, 45 CFR 160.103) *allows identified* patient claims data to be handled by the APCD staff, state agencies and other groups, but apparently the hope is to expand its use even further as part of the SIM plan.

(P. 114) "The dashboard will also be provided to CMMI at regular intervals. Provider-specific performance will be tracked and rewarded as part of the provider scorecard – several of those measures rollup into the overall program Performance Dashboard." The Federal government believes it has the right to give, to at least one state, *identified* Medicare data as part of the APCD. However this state, unlike CT, does not receive fully identified data on the younger patients. How will CT address these two data sets? How much information will be given on all of us to the Federal government? Of course, it does not matter what is officially given as the Federal government can bypass any encryption code. So why are we not allowed to control what information about us will be transferred online in this incredibly extensive and unprecedented SIM program?

If a goal of SIM is to reduce tests and procedures, then it must address tort reform in order for there to be more balance in the decision making between providers and patients, and in ED's. Also malpractice premiums can be so high that it makes it difficult for Ob-Gyn's, for example, to work part time in order to care for their children.

SIM further erodes the free enterprise system in our society in regard to medical care with the underlying narrative that physicians just do volume without regard to good practice, so they need to be brought under control and "transformed." Providers are expected to have the mentality to take on the responsibility of being trusted with our lives while at the same time, are being treated as though they are on perennial parole to keep them from cheating us with their over charges for volume. Along with those attitudes, there is little regard for paying providers fairly for their time, skill, education and costs of practice. Attorneys, who are paid for every minute, and other professionals would not tolerate such a type of work system. In the AMH, there is the expectation that providers will work after hours. How will their 24/7 schedule be compensated? Will they be paid time for overtime as are other workers?

Many physicians are the type of people that chose hard work and heavy responsibilities because they could also be independent practitioners while receiving pleasure from helping others. No money can recompense a physician for what is involved in training for and being a doctor. But it seems that the SIM program wants to select people who want to be spoon-fed, dependent, compliant and non-creative to follow their guidelines. One wonders how many physicians would willingly choose to practice in CT.

Scorecards and P4P after all those years of school, why not just put stars on providers' foreheads as is done for first graders? Will performance and quality care be fairly and accurately determined as physicians will only have advisory input, not the final decisional control, which will rest with SIM. Will fee for service really survive along with the performance score card and P4P?

In the 1980'S, physicians were paid enough to spend time with their patients, coordinate their care and go to the hospital, resulting in whole person medicine and reduction in repeat testing. Because reimbursements have gone down while expenses have gone up, physicians have been driven out of private practice. Now we will have teams of people in the AMH for which one physician will be legally liable.

For providers, whose social security numbers will be taken into data bases, as well as for patients, there are major privacy concerns with the SIM program.

At the "point-of-care" during "Evidence-informed clinical decision making," (p. 6), will physicians have to get permission before making a decision or will it be after -the -fact monitoring? How much time will be spent on computer work to prove that providers have made appropriate medical decisions?

Most importantly, will physicians, now and in the future, have the true autonomy to practice the kind of medicine that is in the best interests of their patients without constraints, which could be based on cost effectiveness rather than best treatments, imposed by external guidelines that may or may not be valid in any given individual patient situation?

Risk sharing for patients sounds great, but how intrusive and pressuring will SIM be on patients?

Will attribution, p. 45, restrict patient choice of their providers?

Will independent providers effectively be squeezed out of practice if they do not collaborate with other providers, p. 45, or with hospital systems, page 49?

... "the State will monitor for signs of market consolidation and consider legal and regulatory action as appropriate, p. 48. So will physicians eventually be forced to comply with SIM?

From: Susan Israel [REDACTED]
Sent: Tuesday, November 05, 2013 9:55 AM
To: SJM, OHA
Subject: Public Comment on SIM

November 5, 2013

The State Innovation Models Initiative is based on taking patient electronic medical records, from the Health Information Exchange and the All Payer Claims Database without patient consent, and putting them into data bases with the hope that they will not be hacked or leaked. This is our most intimate information taken out of our control so that our behavior and that of our providers can be scrutinized to make sure we all cooperate with SIM's "quality" metrics.

Any deviation from the SIM "standard of care" or "cost effectiveness" will have to be explained to the computer. Hopefully, there will be a mini appeals court for patients if they cannot lose weight, stop smoking or take cholesterol lowering drugs, or if they need a procedure that is too costly or not within the "bundling" of care treatment options.

What if a patient with congestive heart failure has a hot dog, against medical advice, and ends up back in the hospital within a few days as often happens? Will that patient be penalized as they will have "screwed up" the providers' quality care statistics and cost the medical system more money?

SIM does not seem to allow patients to pay their providers for their time as they do their lawyers. But that will not matter as there will be little need for the provider - patient relationship, as all will be decided by the SIM boards. So why not save a lot of money and just have robots, computers and cameras, directed by SIM data managers, in the patient exam room for complete transparency and compliance.

Thank you for this opportunity to express concerns at the loss of our liberty and privacy.

Susan Israel